

The issues are: (1) whether appellant met her burden of proof to establish that she sustained reflex sympathetic dystrophy (RSD) causally related to factors of her federal employment; and (2) whether she met her burden to establish that she has greater than a 13 percent impairment of the right upper extremity for which she received a schedule award. On appeal, appellant's counsel argues that the record contains a medical report dated February 5, 1999 which establishes that appellant was entitled to a 26 percent impairment rating for her right upper extremity and that her RSD is employment related.

FACTUAL HISTORY

On July 18, 1997 appellant, then a 43-year-old mail processor, filed an occupational disease claim, alleging that factors of her federal employment caused right elbow tendinitis. The Office accepted this condition. On October 27, 1997 she filed a claim for a left elbow condition, that was accepted for lateral epicondylitis. On December 4, 1997 appellant underwent surgical repair of her right elbow, performed by her attending Board-certified orthopedic surgeon, Dr. Rodger C. Searfoss. She returned to limited duty for four hours a day on January 20, 1998. On March 4, 1998 the claims were consolidated. In July 1998, appellant began working six hours a day. She was then placed on the periodic rolls for two hours per day of wage-loss compensation.

In a treatment note dated March 8, 1998, Dr. Searfoss advised that appellant had some evidence of RSD in her right elbow. In a report dated April 27, 1998, Dr. Bill Hennessey, Board-certified in physical medicine and rehabilitation, found no evidence of RSD. By report dated May 20, 1998, Dr. Michael Sauter, an attending Board-certified neurologist, diagnosed RSD, noting that a bone scan provided confirmation.

The Office referred appellant to Dr. John B. Talbott, a Board-certified neurologist, who provided a July 28, 1998 report which found that appellant did not have RSD. In a January 12, 1999 report, Dr. Searfoss approved a job offer proffered by the employing establishment and, on January 25, 1999, he outlined appellant's job capabilities. By letter dated January 28, 1999, the Office advised appellant that the position offered was suitable. She was notified of the penalty provisions of section 8106 and given 30 days to respond. On March 17, 1999 she filed a schedule award claim. By decision dated April 5, 1999, the Office terminated appellant's wage-loss compensation on the grounds that she refused an offer of suitable work.

On April 14, 1999 appellant, through her attorney, requested a hearing, and submitted additional evidence, which included a February 5, 1999 form report in which Dr. Sauter provided range of motion findings for appellant's right upper extremity and concluded that she had a 26 percent right upper extremity impairment. Dr. Sauter advised that it was likely that appellant would remain at an approximately 15 percent disability rating in a chronic setting. In a February 24, 1999 report, Dr. Searfoss continued to diagnose RSD and advised that this had a "profound effect" on appellant's ability to use her right arm.

At the hearing held on September 29, 1999, appellant testified that she refused the job offer because the working conditions were unsafe. She began working eight hours a day on January 25, 1999. By decision dated March 24, 2000, an Office hearing representative affirmed the April 15, 1999 decision.

On June 22, 2000 appellant, through her attorney, requested reconsideration. A telephone conference was held on October 16, 2000. Appellant indicated that she had retired on October 6, 2000¹ and prior to that time had mostly worked 25 to 30 hours per week. She argued that the job offer was not proper and that her RSD condition should be accepted as employment related.

¹ Appellant's disability retirement was approved by the Office of Personnel Management on September 20, 2000.

By decision dated November 8, 2000, the Office vacated the April 15, 1999 decision on the basis that appellant had not been offered an additional 15 days to accept the job offer and reinstated wage-loss compensation as of April 15, 1999. The Office further found that a conflict in medical evidence existed regarding whether appellant had RSD causally related to her federal employment.

On December 14, 2000 appellant submitted a June 2, 2000 treatment note in which Dr. Maria J. Sunseri, Board-certified in neurology, noted findings on examination and diagnosed right RSD.

On January 4, 2001 the Office referred appellant, the medical record, a statement of accepted facts and a set of questions, to Dr. Guy R. Corsello, a Board-certified neurologist, for an impartial evaluation to determine whether appellant had RSD causally related to her federal employment. In a report dated February 14, 2001, Dr. Corsello noted his review of the detailed records provided, diagnosed bilateral epicondylitis and advised that she had previously had mild RSD in the right arm as documented by a bone scan and physical examination by Dr. Sauter. He opined that she did not have this condition at the time of his examination and opined that the prognosis for recovery was poor because she was unable to use her right dominant hand. Dr. Corsello concluded that she was not employable. Drs. Sunseri, Sauter and Searfoss continued to submit reports in which they reiterated their previous diagnoses and conclusions.

In a letter dated January 8, 2002, the Office accepted bilateral epicondylitis and resolved RSD of the right upper extremity.

By reports dated May 8, 2002, Dr. Searfoss provided range of motion findings for appellant's right upper extremity, advising that her shoulder lacked 10 degrees of forward flexion and 2 degrees of supination, and that abduction, internal rotation and external rotation were normal. He stated that she seemed to have a little hypothenar atrophy, and advised that her elbow had 55 out of 150 degrees of motion. In a report dated July 24, 2002, Dr. Searfoss repeated his range of motion findings and advised that maximum medical improvement had been reached. In a report dated June 16, 2003, he advised that appellant had a 45-degree flexion contracture of her right elbow and lacked 35 degrees of abduction and forward flexion of her right shoulder and 5 degrees of internal rotation.

On October 24, 2003 appellant's attorney forwarded additional medical evidence to the Office, including an October 6, 2003 letter in which Dr. Searfoss advised that appellant developed RSD after her elbow surgery, noting that the RSD symptoms had subsided but she had been left with a permanent loss of mobility. He stated that he was completing an impairment rating. By letter dated October 20, 2003, Dr. Sauter advised that he had completed an attached impairment report. An unsigned form for evaluation of abnormal upper extremity motion was attached which advised that appellant lacked 45 degrees of elbow extension for a 5 percent impairment and lacked 25 degrees of shoulder flexion and 50 degrees of shoulder abduction for an 8 percent shoulder impairment. The two impairments were then combined to equal 13 percent right upper extremity impairment.²

² It is unclear if this report is from Dr. Sauter or Dr. Searfoss. Appellant's attorney indicated that he was submitted two forms, and the Office medical adviser concluded that it was from Dr. Searfoss.

The Office referred the October 3, 2003 medical reports to an Office medical adviser for an opinion regarding appellant's entitlement to a schedule award. By report dated November 14, 2003, the Office medical adviser advised that maximum medical improvement had been reached on October 6, 2003, the date of Dr. Searfoss' report. He concurred that appellant had a 13 percent right upper extremity impairment in accordance with the fifth edition of the A.M.A., *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).³ On December 16, 2003 appellant was granted a schedule award for a 13 percent loss of use of the right arm, for a total of 40.56 weeks, to run from October 6, 2003 to July 15, 2004.

On January 13, 2004 appellant requested a hearing that was held on November 9, 2004. At the hearing appellant's attorney argued that RSD should be accepted as employment related and that she was entitled to 26 percent impairment as found by Dr. Sauter in a February 5, 1999 impairment rating. Appellant also submitted additional evidence including medical reports previously of record, and reports by Drs. Searfoss and Sauter dated July 8, 9 and 14, 2004 in which they reiterated their previous conclusions.

In a report dated November 11, 2004, Dr. Searfoss advised that appellant had reached maximum medical improvement and opined that she had a flexion contracture of 38 percent in her right elbow.

By decision dated January 11, 2005, an Office hearing representative credited the impartial evaluation of Dr. Costello, finding that appellant's RSD had resolved, and affirmed the December 16, 2003 schedule award decision.

LEGAL PRECEDENT -- ISSUE 1

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical opinion must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁴

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.⁵ Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated

³ A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

⁴ *Solomon Polen*, 51 ECAB 341 (2000).

⁵ *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁶ Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.⁷

Regarding how far the range of compensable consequences is carried once the primary injury is causally connected with the employment, Larson notes that when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of “direct and natural results” and of claimant’s own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.⁸ Once the work-connected character of any condition is established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause.⁹

Section 8123(a) of the Federal Employees’ Compensation Act¹⁰ provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination,¹¹ and in situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.¹²

ANALYSIS -- ISSUE 1

The Office found that a conflict of medical opinion was created regarding whether appellant had RSD. It referred appellant to Dr. Corsello for an impartial evaluation. In a report dated February 14, 2001, Dr. Corsello noted his review of the detailed records provided and diagnosed bilateral epicondylitis. He advised that, while appellant had previously had mild RSD in the right arm, as documented by a bone scan and physical examination by Dr. Sauter, this condition had resolved at the time of his examination.

⁶ *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

⁷ *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

⁸ A. Larson, *The Law of Workers’ Compensation* § 10.01 (2000); see *Raymond A. Nester*, 50 ECAB 173 (1998).

⁹ *Id.*; *Charles W. Downey*, 54 ECAB ____ (Docket No. 02-218, issued February 24, 2003).

¹⁰ 5 U.S.C. §§ 8101-8193.

¹¹ 5 U.S.C. § 8123(a).

¹² *Gloria J. Godfrey*, 52 ECAB 486 (2001).

As stated above, if the opinion of the impartial specialist is sufficiently well rationalized and based on a proper factual background, it must be given special weight.¹³ The Board finds that the opinion of Dr. Corsello, the impartial examiner in this case, is entitled to special weight as he provided a thorough, well-rationalized report in which he noted his review of the medical record, the statement of accepted facts and questions provided as well as findings from his examination.

While appellant submitted subsequent medical reports from Drs. Sunseri, Sauter and Searfoss who continued to diagnose RSD, Drs. Sauter and Searfoss had been on one side of the conflict resolved by Dr. Corsello. Their subsequent reports essentially repeated their prior findings and are insufficient to overcome the weight of the referee physician or to create a new conflict of medical opinion.¹⁴ Moreover, in an October 6, 2003 letter, Dr. Searfoss advised that appellant's RSD symptoms had subsided. Although Dr. Sunseri continued to provide diagnoses of RSD in reports dated June 2, 2000 and January 16, 2001, she provided no rationale to support this diagnosis. The Board has long held that medical conclusions unsupported by rationale are of diminished probative value.¹⁵ Appellant's condition of RSD was accepted by the Office but the report of Dr. Corsello establishes that it resolved by the time of his examination and was not disabling.

LEGAL PRECEDENT -- ISSUE 2

Under section 8107 of the Act¹⁶ and section 10.404 of the implementing federal regulation,¹⁷ schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.¹⁸ Chapter 16 provides the framework for assessing upper extremity impairments.¹⁹

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be

¹³ *Solomon Polen*, *supra* note 4.

¹⁴ *Richard O'Brien*, 53 ECAB 234 (2001).

¹⁵ *See Albert C. Brown*, 52 ECAB 152 (2000); *Jacquelyn L. Oliver*, 48 ECAB 232 (1996).

¹⁶ 5 U.S.C. § 8107.

¹⁷ 20 C.F.R. § 10.404.

¹⁸ *See Joseph Lawrence, Jr.*, *supra* note 3; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

¹⁹ A.M.A., *Guides*, *supra* note 3 at 433-521.

itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*. However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.²⁰

It is well established that the period covered by the schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The Board has explained, and the A.M.A., *Guides* provides, that maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.²¹ It is understood that an individual's condition is dynamic, and maximum medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached maximum medical improvement, a permanent impairment rating may be performed.²² The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record, and is usually considered to the date of the evaluation by the attending physician which is accepted as definitive by the Office.²³

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that she has greater than a 13 percent right upper extremity impairment. In determining appellant's schedule award, the Office relied on a report submitted by an attending physician which provided an impairment rating indicating that appellant had a 5 percent right elbow impairment, based on an extension of 45 degrees, and an 8 percent right shoulder impairment based on flexion of 125 degrees and abduction of 89 degrees. These were combined to total a 13 percent right upper extremity impairment.²⁴ This report was reviewed by an Office medical adviser who, on November 14, 2003, found that maximum medical improvement had been reached and that appellant had 13 percent right upper extremity impairment.

Appellant argues on appeal that a February 5, 1999 impairment rating in which Dr. Sauter found that she had a 26 percent right upper extremity impairment should be utilized in determining her schedule award. As noted, the period covered by the schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury which means that the physical condition of the injured member of the body has stabilized and will not improve further.²⁵ Obviously, appellant's

²⁰ *Robert V. Disalvatore*, 54 ECAB ____ (Docket No. 02-2256, issued January 17, 2003).

²¹ *Mark A. Holloway*, 55 ECAB ____ (Docket No. 03-2144, issued February 13, 2004); see A.M.A., *Guides*, *supra* note 1 at 19.

²² *Patricia J. Penney-Guzman*, 55 ECAB ____ (Docket No. 04-1052, issued September 30, 2004).

²³ *Mark A. Holloway*, *supra* note 21.

²⁴ The Board notes that the record does not indicate that a shoulder condition has been accepted as employment related.

²⁵ *Mark A. Holloway*, *supra* note 21; see A.M.A., *Guides*, *supra* note 3 at 19.

right upper extremity condition improved between 1999 and the 2003 evaluation on which the present schedule award was based. Furthermore, in a report attached to his February 5, 1999 impairment rating, Dr. Sauter advised that it was likely that appellant would have a 15 percent chronic disability rating which indicates that maximum medical improvement had not been reached. Appellant had not reached maximum medical improvement in February 1999 and was not entitled to a schedule award at that time.

As found by the Office medical adviser, Figure 16-34 of the A.M.A., *Guides* provides that 45 degrees of extension is equal to a 5 percent impairment,²⁶ and Figures 16-40 and 16-43 indicate that 125 degrees of shoulder flexion and 89 degrees of shoulder abduction are equal to 4 percent impairments each for an 8 percent shoulder impairment.²⁷ The Office medical adviser then determined that under the Combined Values Chart, a 5 percent elbow impairment combined with a 13 percent shoulder impairment was equal to a 13 percent right upper extremity impairment.²⁸

While appellant submitted a November 11, 2004 treatment note in which Dr. Searfoss reported a 38 percent flexion contracture, this would not provide an increased award pursuant to Figure 16-34.²⁹ The Board therefore finds that the record establishes that appellant is not entitled to a schedule award for her right upper extremity of greater than 13 percent.³⁰

CONCLUSION

The Board finds that appellant's RSD condition has resolved and that she failed to establish that she is entitled to more than a 13 percent schedule award for the right upper extremity.

²⁶ A.M.A., *Guides*, *supra* note 3 at 472.

²⁷ *Id.* at 476-77.

²⁸ *Id.* at 604.

²⁹ *Id.* at 472.

³⁰ See *Mary L. Henninger*, 52 ECAB 408 (2001).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 11, 2005 is affirmed.

Issued: October 6, 2005
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board